

## MOMS Physician

*(PCAP contractor – enter Specialty Code 159 on claim)*

Procedure Code	Description	Maximum Fee
59409	Vaginal delivery only (with or without episiotomy, and/or forceps); (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits *).	\$883
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); (when only <b>inpatient</b> postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits.	883
59514	Cesarean delivery only; (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits *).	883
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; (when only <b>inpatient</b> postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)	883

**NOTE:** Inpatient hospital visits should **not** be billed with MOMS specialty code 159. Bill visits (E/M codes) on a separate claim with the appropriate physician specialty code (e.g. 089 – Obstetrics and Gynecology, or 050 – Family Practice).

## Sample 2

## MOMS PHYSICIAN – PCAP CONTRACTOR

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM		CONSORT CODE 0460	SPECIAL CODE 159	ONLY TO BE USED TO ADJUST/VOID/ID CLAIM	CODE A V	ORIGINAL CLAIM REFERENCE NUMBER
<b>PATIENT AND INSURED (SUBSCRIBER) INFORMATION</b>						
1. PATIENT'S NAME (first name, middle initial, last name) <b>Theresa Evans</b>		3. PATIENT'S BIRTH DATE <b>68</b>		3A. TOTAL ANNUAL FAMIL Y INCOME		3. INSURED'S NAME (first name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)		6. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>		6A. INSURED'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		8. MEDICARE NUMBER 9A. MEDICARE NUMBER
5. PATIENT'S TELEPHONE NUMBER		7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. PRIVATE INSURANCE NUMBER GROUP NO. <b>A1M61216131T</b> INDIVIDUAL NO.		8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE – State Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number		10. WAS COVERAGE RELATED TO PATIENT'S EMPLOYMENT <input type="checkbox"/> CRIME VICTIM <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER LIABILITY <input type="checkbox"/>		11. INSURED'S ADDRESS (Street, City, State, Zip Code)		11
12. PATIENT'S OR AUTHORIZED SIGNATURE		DATE		12. INSURED'S SIGNATURE		
<b>PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)</b>						
13. DATE OF ONSET OF CONDITION	13C. FIRST CONSULTED FOR CONDITION	13C. HAD PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES <input type="checkbox"/> NO <input type="checkbox"/>	13A. EMERGENCY RELATED YES <input type="checkbox"/> NO <input type="checkbox"/>	17. DATE PATIENT MAY RETURN TO WORK	18. DATES OF DISABILITY TOTAL <input type="checkbox"/> PARTIAL <input type="checkbox"/>	18C. IDENTIFICATION NUMBER
16. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		16A. ADDRESS (OR SSANUM) (34P DCL V)		18B. TYPE		18C. IDENTIFICATION NUMBER
16. FOR SERVICES RENDERED TO HOSPITALIZATION - GIVE HOSPITALIZATION DATES		16A. NAME OF HOSPITAL		18B. SURGERY DATE		18C. TYPE OF SURGERY
17. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)		17A. ADDRESS OF FACILITY		19. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES <input type="checkbox"/> NO <input type="checkbox"/>		19C. CHARGE
20A. SERVICE PROVIDER NAME		20B. Type		20C. IDENTIFICATION NUMBER		20D. EPDUT CHRP
21. DIAGNOSIS OR NATURE OF ILLNESS. (RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24F BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR SK CODE)		21A. ADDRESS OF FACILITY		21B. IDENTIFICATION NUMBER		21C. STATUS CODE
22. DATE OF SERVICE		22A. PLACE TYPE		22B. SOURCE CODE		22C. PROCEDURE CODE
23. DATE OF SERVICE		23A. PLACE TYPE		23B. SOURCE CODE		23C. PROCEDURE CODE
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